STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445128	A. BUILDING _____ B. WING _____	12/22/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, OAK RIDGE	300 LABORATORY RD OAK RIDGE, TN 37831

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual recertification survey and complaint investigation #26969 were completed on December 20 - 22, 2010, at NHC Healthcare of Oak Ridge. No deficiencies were cited related to complaint investigation #26969 under CFR Part 483, Requirements for Long Term Care Facilites.	F 000		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431	1. The out of date collection tubes, IV start kits, and female catheter kits were immediately removed from medication room and discarded. 2. All collection tubes, IV start kits, and catheter insertion kits were checked for compliance of expiration date on 12-21-10 after survey team brought out of date items to our attention. 3. The licensed nursing staff will be inserviced on 1-11-11 at 10am, 2pm, 3:15pm, 6pm, or 1-13-11 at 10am, 2pm, 3:15pm, 6pm, or 1-14-11 at 10am, 2pm, 3:15pm, or 6pm. The central supply clerk will monitor nursing and laboratory supplies to ensure compliance of expiration date. 4. Each month no later than the 7th day, the central supply clerk will check all supplies and biologicals to ensure they are within the expiration date.	1-14-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

JAN 07 2011

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F 431	Continued From page 1 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure biologicals were stored appropriately and within expiration date for one of two medication rooms. The findings included: Observation of the medication room on W-2 wing on December 21, 2010, at 10:00 a.m., revealed: 1. Eleven blue top BD vacutainers (blood collecting tubes) expired September 2010. 2. Three purple top BD vacutainers expired October 2010. 3. One BD IV (intravenous) start kit was opened with some contents removed. 4. Two BD IV start kits expired June 2010. 5. One female catheter kit with gloves and swabs (Put catheter in bladder) expired April 2010. Continued observation of the medication room revealed these items were in the cabinets and available for use in resident care. Interview with the Licensed Practical Nurse on duty on December 21, 2010, at 10:50 a.m., in the medication room confirmed all the articles were expired, should have been removed from the cabinets, and were still available for use in resident care.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB	F 514	1. For resident #22 the nursing supervisor along	

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F 514	Continued From page 2 LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility failed to ensure accurate Intake/Output records for one resident (#22) of twenty-six residents reviewed. The findings included: Resident #22 was admitted to the facility on January 26, 2010, with diagnoses including Coronary Artery Disease, Percutaneous Coronary Angiography with Stent, Hypertension, Pacemaker Insertion, Atrial Fibrillation, Gastroesophageal Reflux Disease, Congestive Heart Failure, Osteoporosis, Osteoarthritis, and End Stage Renal Disease requiring Dialysis. Medical record review of the Minimum Data Set dated November 18, 2010, revealed the resident had moderate cognitive impairment with short term memory deficits, required assistance with Activities of Daily Living and ambulation, was	F 514	with dietician will divide the 1500ml/24hr physician order into # mls to be provided by dietary on meal trays and mls to be offered by nursing will be divided into two shifts so each shift will have a specific # of mls to be available to be offered. 2. Each patient admitted will follow the same above guideline. Dietician, nursing will document # mls to be offered by nursing in two divided shifts. 3. The order when received by M.D. will be reviewed by dietary and nursing supervisor. Dietary will divide # of mls to be offered by dietary on meal trays. Dietary along with nursing supervisor will divide remaining mls into two shifts. Nursing will document each shift that order is being followed on MAR. All licensed nursing staff will be inserviced on 1-11-11, 1-13-11, and 1-14-11 at 10am, 2pm, 3:15pm, or 6pm each day. The dietician and nursing supervisor will review the new recaptulation orders for compliance.	

APN

JAN 07 2011

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F 514	Continued From page 3 occasionally incontinent of bowel and bladder, and had dialysis access in the right upper extremity. Medical record review of the physician's Recapitulation Orders dated September 2010, October 2010, November 2010, and December 2010, stated "Fluid restriction 1500 ml (milliliters) in 24 hours. Dietary to provide 1080 ml; nursing to provide 420 ml in 24 hours." Medical record review of the Intake and Output records revealed no documentation of intake on a regular basis. Continued medical record review revealed no documentation of the resident's intake on five occasions on the 7:00 a.m. - 7:00 p.m,. shift and on twelve occasions on the 7:00 p.m. - 7:00 a.m., shift during September; on six occasions on the 7:00 a.m. - 7:00 p.m., shift and on ten occasions on the 7:00 p.m. - 7:00 a.m., shift during October; on sixteen occasions on the 7:00 a.m. - 7:00 p.m. shift and on fifteen occasions on the 7:00 p.m. - 7:00 a.m., shift during November. Review of the facility's Encouraging and Restricting Fluids revealed "...General Guidelines: 1. Follow specific instructions concerning fluid intake or restrictions. 2. Be accurate when recording intake. 3...Record intake in mls...Documentation: The following information should be recorded in the resident's medical record...6. The amount (in mls) of fluids consumed by the resident during the shift..." Interview with the Licensed Practical Nurse on duty on December 21, 2010, at 3:55 p.m., in the W-2 nurses' station confirmed the staff had failed to document the resident's intake accurately.	F 514	4. New recapitulation orders will be reviewed at the beginning of each month to ensure fluid restriction order is correct. This will be done by the nursing supervisor. The current months MAR will be reviewed at the same time to ensure compliance. This will be done by the nursing supervisor.	1-14-11

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ADM

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